

SECTION 8 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT

General Information and Requirements for CMS Quarterly Administrative Expenditure Invoices

- I. The quarterly administrative expenditure invoice forms contain the same five line items used in the budgets.
- II. Counties/cities are **not** required to submit expenditure justification worksheets with quarterly administrative invoices. However, justification worksheets and/or documentation of how expenditure amounts were derived must be maintained at the county/city level for audit purposes.
- III. Quarterly expenditure invoices for salaries and wages must be supported by time studies or attendance documentation maintained at the county/city level for audit purposes. Documentation for staff who qualify for enhanced federal funding and/or who work on more than one program must include quarterly time studies at a minimum, prepared for each budgeted position using the same representative month each quarter. (See page 9-5 and 9-6).
- IV. Tools for using time study information to allocate personnel services and benefits expenses are included in References, Section 10.
- V. Overhead costs submitted on the quarterly invoices must be consistent with the county/city cost allocation plans for the approved invoicing period. Internal overhead costs must be prepared in accordance with the Office of the Assistant Secretary, Comptroller (OASC) 10 federal guidelines. External overhead costs invoiced for reimbursement must be based on the plan approved by the State Controller's Office (A-87 approval letter). Documentation must be maintained by the county/city for audit purposes.
- VI. Invoices must list **actual** expenditures made during the quarter for items approved in the budget justification worksheet, with the following exceptions:
 - A. Indirect costs are approved estimates for invoicing purposes based on federal OASC-10 cost allocation methods.
 - B. Staff benefits may be invoiced at an estimated rate for three quarters but must be adjusted to actual costs on the fourth quarter invoice.
 - C. Counties may not invoice for goods (e.g., equipment, printing, videos, etc.) until after they have actually been received. Budgeted goods that are supported by a purchase order, issued in the budget and for which funds are encumbered may not be received until the following fiscal year. These costs may be included on the fourth quarter invoice or submitted on a supplemental invoice for the fiscal year in which they were encumbered.

- VII. For questions concerning the appropriate line item usage for an expense, refer to Section 6 for the definitions of the five line item categories listed on the quarterly invoice or contact the regional administrative consultant/analyst.
- VIII. Round all figures to the nearest whole dollar; 50 cents or more is rounded up, and 49 cents and less is rounded down.
- IX. Quarterly invoices for expenditures authorized in CMS budgets shall be submitted no later than 60 days after the end of each quarter.
- A. First Quarter invoice (time period of July 1 through September 30) is due by November 30.
 - B. Second Quarter invoice (time period of October 1 through December 31) is due by February 28.
 - C. Third Quarter invoice (time period of January 1 through March 31) is due by May 31.
 - D. Fourth Quarter invoice (time period of April 1 through June 30) is due by August 31.
 - E. Supplemental invoices will only be accepted up to 6 months after the close of the fiscal year for which they apply. The fiscal year ends June 30; therefore December 31 would be the last day to submit supplemental invoices for any given fiscal year.
- X. Headings on invoices must contain the identification items identified below. Additional information as identified in the specific and separate CCS or CHDP instructions must also be provided:
- A. Program name (i.e., CCS, CHDP)
 - B. Name of county or city
 - C. Fiscal year of invoicing period
 - D. Quarter ending date
 - Quarter 1 ends September 30;
 - Quarter 2 ends December 31;
 - Quarter 3 ends March 31; and
 - Quarter 4 ends June 30.
- XI. **Signature/Certification blocks** must contain at a minimum the following, with additional information as identified in the specific and separate CCS or CHDP instructions:
- A. Contact person name and telephone number

- B. Signatures of authorized officials certifying the accuracy of the expenditures reported.
- C. Date signed.

NOTE: Invoices submitted without signatures will be returned for authorized signatures before being processed for payment.

- XII. Invoices that exceed budgeted funding sources or do not compute will be returned for corrections.
- XIII. Agencies are responsible for federal audit exceptions and must identify the State in the event any exceptions are found.

CHDP Quarterly Administrative Expenditure Invoice Instructions

The CHDP Quarterly Administrative Expenditure Invoice (No County/City Match) form is on Page 8-10. The CHDP Quarterly Administrative Expenditure invoice (County/City Match) form is on Page 8-11. All invoices must be prepared in accordance with these instructions in order to receive reimbursement for county/city administrative expenditures.

I. Instructions for Preparation of CHDP Quarterly Administrative Expenditure Invoices (No County/City Match)

CHPD administrative expenditures are reimbursed according to the individual county/city percentages of the Medi-Cal and non-Medi-Cal portions of the approved program's budget.

An exception to application of the non Medi-Cal percentage is for an expenses qualifying as 100 percent Medi-Cal funded, i.e., costs of services exclusively for Medi-Cal eligibles. A county/city program having a category or line item that includes expenses designated as 100 percent Medi-Cal must asterisk (*) the category, footnote the specific amount and have supporting documentation on file. All other expenses have the non-Medi-Cal percentage rate of the individual county/city approved budget applied to distribute the Medi-Cal and non Medi-Cal share of the expenses.

Column 1 will always be the sum of Column 2 and Column 3 for each category/line item. Column 3 will always be the sum of Column 4 and Column 5 for each applicable category/line item.

A. Category/Line Item

1. (I.) Total Personnel Expenses

Enter the total amount for "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total of non Medi-Cal personnel services claimed in Column 2. This number is derived by multiplying the total expenditures for personnel services in Column 1 by the percentage of the non Medi-Cal share on the approved budget.

Enter the total amount of personnel services expenditures claimed for reimbursement from Medi-Cal in Column 3. This number is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for personnel expenses.

Enter the total amount of Medi-Cal Personnel services claimed for enhanced funds in Column 4 and the total amount claimed for non enhanced funds in Column 5. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1 on this line, the total of all operating expenses.

Enter the non Medi-Cal amount claimed of operating expenses in Column 2. This amount is derived by multiplying the Total Operating Expenses in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for operating expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 4 and enter the nonenhanced operating expenses claimed in Column 5.

NOTE: Only travel and training expenses may qualify as operating expenses in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. (III) Total Capital Expenses

Enter in Column 1, the total of all capital expenses. The definitions of equipment and prerequisites for reimbursement are found on Page 8-70.

Enter in Column 2, the amount of Non Medi-Cal capital expenses. This amount is derived by multiplying the Total Capital Expenses amount in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for capital expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for Capital Expenses.

Enter the Capital Expenses amount from Column 3 into Column 5, nonenhanced.

4. (IV) Total Indirect Expenses

Enter in Column 1, the total of all Indirect Expenses.

Enter the amount of non Medi-Cal indirect expenses in Column 2. This amount is derived by multiplying the total indirect expenses amount in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for indirect expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for the indirect expenses.

Enter the indirect expenses amount from Column 3 in Column 5, non enhanced.

5. (V) Total Other Expenses

Enter the total of all other expenses on this line in Column 1.

Enter in Column 2, the non Medi-Cal other expenses. This amount is derived by multiplying the total Other Expenses amount in Column 1 by the percentage of the non Medi-Cal share of the approved budget.

Enter the Medi-Cal amount claimed for other expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount in Column 1 for Other Expenses.

Enter the amount claimed for Other Expenses from Column 3 into Column 5, nonenhanced.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds

1. State

Enter the amount for State in Column 2. This amount is the same as the Expenditure Grand Total amount for TOTAL CHDP Non Medi-Cal.

2. Medi-Cal Funds

The Medi-Cal Funds under the Source of Funds are calculated beginning with Column 4, Enhanced State/Federal and Column 5, State/Federal.

a. Enhanced State/Federal

Multiply the Expenditure Grand Total line of Column 4, Enhanced by 25 percent and enter this amount on the State Funds line in Column 4.

Subtract the amount of State Funds for Column 4, Enhanced from the Expenditure Grand Total line of Column 4 and enter this amount on the Federal Funds line in Column 4.

b. Nonenhanced State/Federal

Multiply the Expenditure Grand Total line of Column 5, Nonenhanced by 50 percent and enter this amount on the State Funds line for Column 5.

Subtract the amount of State Funds for Column 5, Nonenhanced from the Expenditure Grand Total line of Column 5 and enter this amount on the Federal Funds line in Column 5.

c. Total Medi-Cal Funds

Enter in Column 3 on the State Funds line the total of Column 4 and Column 5, State Funds.

Enter in Column 3 on the Federal (Title XIX) Funds line the total of Column 4 and Column 5, Federal (Title XIX) Funds.

3. Total Funds

Enter in Column 1, Total Funds for the State Funds (non Medi-Cal) line, the same amount as entered in Column 2, Total CHDP Funds.

Add Columns 4 and 5 together for the State Funds line under Medi-Cal Funds and enter the total in Column 3, total Medi-Cal and Column 1, Total Funds.

Add Columns 4 and 5 together for the Federal (Title XIX) Funds line and enter the total in Column 3, Total Medi-Cal Funds, and Column 1, Total Funds.

NOTE: The totals of funding amounts entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the "Expenditure Grand Total" line.

C. Certification and Signatures

Provide a contact name and telephone number for county or city staff responsible for compiling the expenditure invoice.

Certify the accuracy and policy compliance of the reported expenditures by signing and dating the completed invoice form.

II. Instructions for Preparation of the CHDP Quarterly Administrative Expenditure Invoice Form (County/City Match)

The county/city match invoice for expanded services for Medi-Cal recipients is 100 percent county/city funds with federal fund match. No State Funds are included on this invoice.

A. Category/Line Item

1. (I) Total Personnel Expenses

Enter the total amount of "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time

study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total amount of personnel expenses invoiced in Column 2 for enhanced funding and the total amount invoiced in Column 3 for nonenhanced funding. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1, the total of all operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 2 and enter the nonenhanced operating expenses claimed in Column 3.

NOTE: Only travel and training expenses may qualify as operating expenses for enhanced funding, and only when claimed by an SPMP following specific FFP guidelines (See Section 9).

3. (III) Total Capital Expenses

Enter the total Capital Expenses on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found on Page 8-70.

4. (IV) Total Indirect Expenses

Enter the total Indirect Expenses on this line in Column 1 and Column 3.

5. (V) Total Other Expenses

Enter the total other expenses on this line in Column 1 and Column 3.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds.

1. County/City Funds

County/city expenditures must meet the Federal Title XIX funding match requirements to obtain this reimbursement but county/city matching funds are not reimbursed. Therefore, a county/city fund line is not completed on the invoice form.

2. Federal (Title XIX) Funds

a. Enhanced Funds

Multiply the Enhanced "Expenditure Grand Total" amount (Column 2) by 75 percent. Enter the amount on the "Federal (Title XIX) Funds" line, Enhanced, in the "Source of Funds" section.

b. Nonenhanced Funds

Multiply the Nonenhanced "Expenditure Grand Total" amount (Column 3) by 50 percent. Enter this amount on the "Federal (Title XIX) Funds" line, Nonenhanced, in "Source of Funds" section.

c. Total Funds

Add Columns 2 and 3 together for the Federal (Title XIX) Funds line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Provide the contact name and telephone number of the county/city staff who is responsible for processing the expenditure invoice.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice. An original signature is required (signature stamps are not acceptable).

Type or print the name and title of the official who signed the invoice.

State of California - Health & Human Services Agency

COUNTY/CITY

Department of Health Services - Children's Medical Services
QUARTER ENDING: _____

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(No County / City Match)
FISCAL YEAR _____

MONTH/DATE/YEAR

CATEGORY/LINE ITEM	TOTAL EXPENDITURES (COLUMNS 2 + 3)	TOTAL CHDP <i>Non Medi-Cal</i>	TOTAL MEDI-CAL (COLUMNS 4 + 5)	ENHANCED STATE/FEDERAL 25/75	NONENHANCED STATE/FEDERAL 50/50
COLUMN	1	2	3	4	5
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURE GRAND TOTAL					

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL	NONENHANCED STATE/FEDERAL
COLUMN	1	2	3	4	5
STATE GENERAL FUNDS					
MEDI-CAL FUNDS:					
STATE					
FEDERAL (TITLE XIX)					

Prepared By

Date

Telephone Number

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director

Date

Revision Date: November 2003

State of California - Health & Human Services Agency

COUNTY/CITY

Department of Health Services - Children's Medical Services
QUARTER ENDING: _____

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
(County / City Match)
FISCAL YEAR _____

MONTH/DATE/YEAR _____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES (COLUMNS 2 + 3)	ENHANCED COUNTY/FEDERAL 25/75	NONENHANCED COUNTY/FEDERAL 50/50
COLUMN	1	2	3
I. TOTAL PERSONNEL EXPENSES			
II. TOTAL OPERATING EXPENSES			
III. TOTAL CAPITAL EXPENSES			
IV. TOTAL INDIRECT EXPENSES			
V. TOTAL OTHER EXPENSES			
EXPENDITURE GRAND TOTAL			

SOURCE OF FUNDS	TOTAL FUNDS	ENHANCED COUNTY/FEDERAL	NONENHANCED COUNTY/FEDERAL
COLUMN	1	2	3
FEDERAL (TITLE XIX)			

Prepared By _____

Date _____

Telephone Number _____

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director _____

Date _____

Revision Date: November 2003

HPCFC Quarterly Administrative Expenditure Invoice Instructions

In order to receive reimbursement for Health Care Program for Children in Foster Care (HPCFC) expenditures, the Quarterly HPCFC Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The HPCFC Quarterly Administrative Expenditure Invoice form is found on Page 8-15.

The HPCFC Quarterly Administrative Expenditure Invoice (No County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the invoice form. Local county and city Child Health and Disability Prevention (CHDP) programs administering the HPCFC are reimbursed for the actual administrative costs according to the amount of State General Funds and Federal Funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative invoices is on Page 8-1, Plan and Fiscal Guidelines Manual.

A. Category/Line Item

1. Total Personnel Expenses (see I. Total Personnel Expenses on the invoice form).

Enter the total amount of Personnel Expenses for the quarter in Column 1. This is the total expenditure for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of state and federal funds at the enhanced percentage in Column 2.

Enter the total amount of state and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other applicable documentation.

The Total invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form)

Enter the total amount of state and federal funds for the quarter in Column 1.

Enter the total amount of enhanced travel and training expenses in Column 2.

Enter the non-enhanced travel and training expenses in Column 3.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

NOTE: Only travel and training expenses may qualify in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see the shaded area III. Total Capital Expense on the Invoice form.)

Total Capital Expenses are not allowed on the HCPCFC Administrative Budget.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

Indirect expenses are non-enhanced, they may not be claimed at the enhanced rate.

Enter the total of internal indirect expenses for the quarter in Columns 1 and 3.

The total Invoiced amount in Column 1 is the same as the amount in Column 3.

5. Total Other Expenses (see the shaded area V. Total Other Expenses on the Invoice form).

Total other expenses are not allowed on the HCPCFC Administrative Budget

6. Expenditure Grand Total (see Expenditure Grand Total on the Invoice form).

Enter the sum of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the invoice form.

B. Source of Funds

1. State

Enter the amount of State General Funds expended for this quarter in Column 1.

The Total State General Funds in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Federal

Enter the amount of Federal Funds (Title XIX) expended for this quarter in Column 1.

The Total Federal Funds (Title XIX) is the sum of the amounts in Columns 2 and 3.

- a. Enhanced State/Federal (Column 2, Source of Funds)

Multiply the Expenditure Grand Total line of Column 2, by 25 percent.
Enter this amount in the State Funds line of Column 2.

Subtract the amount of State Funds in Column 2, from the Expenditure Grand Total line of Column 2. Enter this amount in the Federal Funds (Title XIX) line in Column 2.

b. Non-enhanced State/Federal (Column 3, Source of Funds)

Multiply the Expenditure Grand Total line of Column 3 by 50 percent. Enter this amount in the State Funds line of Column 3.

Subtract the amount of State Funds in Column 3, from the Expenditure Grand Total line of Column 3. Enter this amount in the Federal Funds (Title XIX) line in Column 3.

c. Expenditure Grand Total (Column 1, Source of Funds)

Enter in Column 1 the total of Column 2 and Column 3, in the County/City Funds line.

Enter in Column 1 the total of Column 2 and Column 3, in the Federal Funds (Title XIX) line.

NOTE: The totals of funding amount entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the Expenditure Grand Total line.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the HCPCFC Quarterly Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

NOTE: An original signature is required. Signature Stamps are not acceptable.

Quarter ending: _____

month/date/year

HCPFC Quarterly Administrative Expenditure Invoice

Fiscal Year _____

County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Expenditure Grand Total	\$0	\$0	\$0

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds	\$0	\$0	\$0
Federal Funds (Title XIX)	\$0	\$0	\$0
Expenditure Grand Total	\$0	\$0	\$0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By

Date

Phone Number

CHDP Director or Deputy Director
(Signature)

Date

Phone Number

Instructions for Preparation of Child Health and Disability Prevention (CHDP) Program Foster Care Quarterly Administrative Expenditure Invoice

In order to receive reimbursement for the CHDP Program Foster Care expenditure, the Quarterly Foster Care Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The Foster Care Quarterly Administrative Expenditure Invoice form is on Page 8-20.

The CHDP Foster Care Quarterly Administrative Expenditure Invoice (County/City Match) Instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the Invoice form. Local county and city CHDP Programs administering the CHDP Foster Care Administrative Budget (County/City Match) are reimbursed for the actual administrative costs according to the amount of County/City Funds and Federal Funds (Title XIX) on the Invoice form. General information about Children's Medical Services Quarterly Administrative Invoices is on Page 8-1, Plan and Fiscal Guidelines Manual.

The CHDP Foster Care Administrative Budget (County/City Match) is an optional budget to fund staff working in support of children and youth in out-of-home placement or foster care. Local county/city funds may be matched with Federal Funds (Title XIX) for this budget. No State General Funds are used in this budget or included on the CHDP Foster Care Administrative Expenditure Invoice form.

A. Category/Line Item

1. Total Personnel Expenses (see I. Total Personnel Expenses on the Invoice form).

Enter the total amount of Personnel Expenses for the quarter in Column 1. This amount is the total amount for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of county/city and federal funds at the enhanced percentage in Column 2.

Enter the total amount of county/city and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other application documentation.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form).

Enter the total amount of operating expenses for the quarter in Column 1.

Enter the total amount of enhanced operating expenses in Column 2.

Enter the non-enhanced operating expenses in Column 3.

NOTE: Only travel and training expenses may qualify as operating expense for enhanced funding, and only when claimed by a Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see III. Total Capital Expenses on the Invoice form).

Enter the total amount capital expenses for the quarter on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found on Page 8-69, Plan and Fiscal Guidelines.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

Enter the total amount of indirect expenses for the quarter on this line in Column 1 and Column 3.

5. Total Other Expenses (see V. Total Other Expenses on the Invoice form).

Enter the total other expenses on this line in Column 1 and Column 3.

6. Expenditure Grand Total

Enter the sum of the Total Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses and Other Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the Invoice form.

B. Source of Funds

1. County/City Funds

County/city expenditures must meet the Federal Funds (Title XIX) funding match requirements to obtain this reimbursement. The county/city matching funds are not reimbursed but must be shown on the invoice.

2. Federal Funds (Title XIX)

a. Enhanced Funds

Multiply the Enhanced Expenditure Grand Total amount (Column 2) by 75 percent. Enter the amount on the Federal Funds (Title XIX) line, Enhanced, in the Source of Funds section.

b. Non enhanced Funds

Multiply the non-enhanced Expenditure Grand Total amount, Column 3, by 50 percent. Enter this amount on the Federal Funds (Title XIX) line, Non-enhanced in Source of Funds section.

c. Total Funds

Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the Foster Care Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

NOTE: An original signature is required. Signature stamps are not acceptable.

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Quarter ending: _____
month/date/year

CHDP Foster Care Quarterly Administrative Expenditure Invoice

Fiscal Year _____
County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Expenditure Grand Total	\$0	\$0	\$0

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
County-City Funds	\$0	\$0	\$0
Federal Funds (Title XIX)	\$0	\$0	\$0
Expenditure Grand Total	\$0	\$0	\$0

Source City-County Funds:

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By	Date	Phone Number
CHDP Director or Deputy Director (Signature)	Date	Phone Number

CCS QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS

INITIAL INVOICE

INSTRUCTIONS for COMPLETION

The Initial Invoice is the first invoice prepared for a quarter that is submitted to the Children's Medical Services (CMS) Branch for reimbursement. This means that no other invoice had been previously submitted to the CMS Branch for this particular quarter.

The following are instructions for the completion of the CCS Program Administrative Expenditure Invoice – Initial, which are prepared on a quarterly basis.

Fiscal Year

- 1) Enter the State fiscal year (FY) for which this invoice applies.

County

- 2) Enter the name of the county for which this invoice applies.

Quarter

- 3) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

CCS CASELOAD

Column B – Actual Caseload

Medi-Cal Cases

- 4) Enter the Average Total Cases of Open (Active) Medi-Cal Children.

Calculate the average total cases by adding the total cases of open (active) Medi-Cal Children for each month in the quarter and dividing by 3.

- 5) Enter the number of Potential Cases of Medi-Cal Children.

- 6) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Cases: Healthy Families

- 7) Enter the Average Total Cases of Open (Active) Healthy Families (HF) Children.

Calculate the average total cases by adding the total cases of open (active) HF Children for each month in the quarter and dividing by 3.

- 8) Enter the number of Potential Cases of HF Children.
- 9) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

Non-Medi-Cal Cases: Straight CCS

- 10) Enter the Average Total Cases of Open (Active) Straight CCS Children.

Calculate the average total cases by adding the total cases of open (active) Straight CCS Children for each month in the quarter and dividing by 3.

- 11) Enter the number of Potential Cases of Straight CCS Children.
- 12) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

Total Non-Medi-Cal Cases

- 13) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

- 14) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

- 15) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 16) Enter the percentage for Potential Cases of Medi-Cal Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 17) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Healthy Families

- 18) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 19) Enter the percentage for Potential Cases of HF Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 20) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Straight CCS

- 21) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 22) Enter the percentage for Potential Cases of Straight CCS Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 23) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

Total Non-Medi-Cal Cases Percentage

- 24) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

- 25) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100%.

ADMINISTRATIVE EXPENDITURES

County

- 26) Enter the name of the county for which this invoice applies.

Quarter

- 27) Enter the dates of the quarter for which the invoice applies.

Column C, Total Expenditures

- 28) Enter the total of all expenditures charged during the quarter to each category/line item listed in Column B.
- 29) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the total of respective amounts in Columns D and G.

Column D, Total Non-Medi-Cal

- 30) Enter the amount of Total Non-Medi-Cal expenditures charged during the quarter to each category/line item listed in Column B.

The amount of Total Non-Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Non-Medi-Cal Cases as calculated in Step 24 for CCS Caseload.

The percentage for Total Non-Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Non-Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to non-Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{rcl} + & \text{Total Other Expenses} & \\ - & \underline{\text{All M\&T Expenditures}} & \\ = & \text{Remaining Balance} & \\ \times & \underline{\text{Total Non-Medi-Cal Cases \%}} & \\ = & \text{Share of Total Other Expenses for Total Non-Medi-Cal Cases} & \\ + & \underline{\text{M\&T Expenditures for Non-Medi-Cal Clients}} & \\ = & \text{Amount of Total Other Expenses for Total Non-Medi-Cal Cases} & \end{array}$$

- 31) Enter the Total Expenditures for Total Non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the total of respective amounts in Columns E and F

Column E, Straight CCS

- 32) Enter the amount of Straight CCS expenditures charged during the quarter to each category/line item listed in Column B.

The amount of Straight CCS expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total Straight CCS Cases as calculated in Step 23 for CCS Caseload.

- 33) Enter the Total Expenditures for Straight CCS by adding all entries in Column E.

Column F, Healthy Families (HF)

- 34) Enter the amount of HF expenditures charged during the quarter to each category/line item listed in Column B.

The amount of HF expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total HF Cases as calculated in Step 20 for CCS Caseload.

- 35) Enter the Total Expenditures for HF by adding all entries in Column F.

Column G, Total Medi-Cal

- 36) Enter the amount of Total Medi-Cal expenditures charged during the quarter to each category/line item listed in Column G.

The amount of Total Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Medi-Cal Cases as calculated in Step 17 for CCS Caseload.

The percentage for Total Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{rcl}
 + & \text{Total Other Expenses} & \\
 - & \text{All M\&T Expenditures} & \\
 = & \text{Remaining Balance} & \\
 \times & \text{Total Medi-Cal Cases \%} & \\
 = & \text{Share of Total Other Expenses for Total Medi-Cal Cases} & \\
 + & \text{M\&T Expenditures for Medi-Cal Clients} & \\
 = & \text{Amount of Total Other Expenses for Total Medi-Cal Cases} &
 \end{array}$$

- 37) Enter the Total Expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the total of respective amounts in Columns H and I.

Column H, Medi-Cal Enhanced

- 38) Enter the amount of Medi-Cal Enhanced expenditures charged during the quarter to Total Personnel Expenses and Total Operating Expenses listed in Column B.

The amount of expenditures charged to Personnel Expenses is based on time studies for:

- a. Skilled Professional Medical Personnel (SPMP) who meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skill, and
- b. Clerical staff who directly support and are supervised by the SPMP.

Only training and travel costs for SPMP are allowed as expenditures for Operating Expenses.

Medi-Cal Enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

Column I, Medi-Cal Non-Enhanced

- 39) Enter the amount of Medi-Cal Non-Enhanced expenditures charged during the quarter to each category/line item listed in Column B.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; ancillary staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

The amount of Medi-Cal Non-Enhanced expenditures for each category/line item listed in Column B is determined by subtracting the entries in Column H from the corresponding entries in Column G.

Maintenance & Transportation

- 40) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, Straight CCS, Healthy Families, and Total Medi-Cal for maintenance & transportation.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and Healthy Families.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

SOURCE OF FUNDS

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M, Straight CCS

- 41) Enter the amount of State and County funds that were used to pay Straight CCS expenditures.

The funding distribution for Straight CCS expenditures is 50% State funds and 50% County funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column E by 50%.

The amount of County funds is determined by multiplying the Total Expenditures in Column E by 50%.

- 42) Enter Total Source of Funds by adding all entries in Column M.

Column N, Healthy Families

- 43) Enter the amount of Federal, State, and County funds that were used to pay Healthy Families expenditures.

The funding distribution for Healthy Families expenditures is 65% Federal (Title XXI) funds, 17.5% State funds, and 17.5% County funds.

The amount of Federal (title XXI) funds is determined by multiplying the Total Expenditures in Column F by 65%.

The amount of State funds is determined by multiplying the Total Expenditures in Column F by 17.5%.

The amount of County funds is determined by multiplying the Total Expenditures in Column F by 17.5%.

- 44) Enter Total source of Funds by adding all entries in Column N.

Column L, Total Non-Medi-Cal

- 45) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 46) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the total of respective amounts in Columns M and N.

Column P, Medi-Cal Enhanced

- 47) Enter the amount of State and Federal funds that were used to pay Medi-Cal Enhanced expenditures.

The funding distribution for Medi-Cal Enhanced expenditures is 25% State funds and 75% Federal (Title XIX) funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column H by 25%.

The amount of Federal (Title XIX) funds is determined by multiplying the Total Expenditures in Column H by 75%.

- 48) Enter Total Source of Funds by adding all entries in Column P.

Column Q, Medi-Cal Non-Enhanced

- 49) Enter the amount of State and Federal funds that were used to pay Medi-Cal Non-Enhanced expenditures.

The funding distribution for Medi-Cal Non-Enhanced expenditures is 50% State funds and 50% Federal (Title XIX) funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column I by 50%.

The amount of Federal (Title XIX) funds is determined by multiplying the Total Expenditures in Column I by 50%.

- 50) Enter Total Source of Funds by adding all entries in Column Q.

Column O, Total Medi-Cal

- 51) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.
- 52) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the total of respective amounts in Columns P and Q.

Column K, Total Expenditures

- 53) Enter the amounts for Medi-Cal State and Federal (Title XIX) funds from Column O to Column K.
- 54) Enter the amounts for Healthy Families State, County, and Federal (Title XXI) funds from Column N to Column K.
- 55) Enter the amounts for Straight CCS State and County funds from Column M to Column K.

Total Source of Funds

- 56) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

CERTIFICATION

- 57) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices.
- 58) Type or print the name of the authorized official.
- 59) Enter the date that the signature was affixed.
- 60) Type or print the name of the contact person for the expenditure invoice.
- 61) Enter the telephone number for the contact person.

SUBMISSION

- 62) Submit the invoice with original signature.

No additional copies are required.

- 63) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

Department of Health Services
Children's Medical Services Branch
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413
Attention: Program Support Section

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

<u>Quarter</u>	<u>Due Date</u>
1 st	November 30, 200x
2 nd	February 28, 200x+1
3 rd	May 31, 200x+1
4 th	August 31, 200x+1

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM

FISCAL YEAR _____

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL

COUNTY _____

QUARTER _____

CCS CASELOAD	ACTUAL CASELOAD	PERCENT OF GRAND TOTAL
A	B	C
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL

COUNTY: _____

QUARTER: _____

A	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT	HEALTHY	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
				CCS 50/50 State/County	FAMILIES 65/17.5/17.5 Fed/State/Co			
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	TOTAL EXPENDITURES							
	Maintenance & Transportation	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
	SOURCE OF FUNDS							
	J	K=L+O	L	M	N	O=P+Q	P	Q
	MEDI-CAL							
	State Funds							
	Federal Funds (Title XIX)							
	HEALTHY FAMILIES							
	State Funds							
	County Funds							
	Federal Funds (Title XXI)							
	STRAIGHT CCS							
	State Funds							
	County Funds							
	TOTAL SOURCE OF FUNDS							

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official		Date		Type or Print Name of Contact Person	
				()	
Type or Print Name of Authorized Official		Date		Telephone Number	

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM

FISCAL YEAR 2004-2005

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL

COUNTY ANYWHEREQUARTER July 1, 2004 - September 30, 2004

CCS CASELOAD	ACTUAL CASELOAD	PERCENT OF GRANT TOTAL
A	B	C
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children	1,736	62.65%
Potential Cases of Medi-Cal Children	218	7.87%
TOTAL MEDI-CAL CASES	1,954	70.52%
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	0	0.00%
Potential Cases of HF Children	0	0.00%
TOTAL HEALTHY FAMILIES CASES	0	0.00%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	631	22.77%
Potential Cases of Straight CCS Children	186	6.71%
TOTAL STRAIGHT CCS CASES	817	29.48%
TOTAL NON-MEDI-CAL CASES	817	29.48%
TOTAL CASELOAD	2,771	100.00%

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIALCOUNTY: ANYWHEREQUARTER: July 1, 2004 - September 30, 2004

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS 50/50 State/County	HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
A	B	C=D+G	D=E+F	E	F	G=H+I	H	I
I.	Total Personnel Expenses	197,512	58,227	58,227	0	139,285	98,436	40,849
II.	Total Operating Expenses	49,207	14,506	14,506	0	34,701	26,507	8,194
III.	Total Capital Expenses	0	0	0	0	0		0
IV.	Total Indirect Expenses	23,611	6,961	6,961	0	16,650		16,650
V.	Total Other Expenses	8,053	1,000	1,000	0	7,053		7,053
	TOTAL EXPENDITURES	278,383	80,693	80,693	0	197,690	124,943	72,747
	Maintenance & Transportation	\$ 4,500	\$ 750	\$ 250	\$ 500	\$ 3,750		
	SOURCE OF FUNDS							
	J	K=L+O	L	M	N	O=P+Q	P	Q
	MEDI-CAL							
	State Funds	67,609				67,609	31,236	36,373
	Federal Funds (Title XIX)	130,081				130,081	93,707	36,373
	HEALTHY FAMILIES							
	State Funds	0	0		0			
	County Funds	0	0		0			
	Federal Funds (Title XXI)	0	0		0			
	STRAIGHT CCS							
	State Funds	40,347	40,347	40,347				
	County Funds	40,347	40,347	40,347				
	TOTAL SOURCE OF FUNDS	278,383	80,693	80,693	0	197,690	124,943	72,747

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

					Jane Doe	
Signature of Authorized Official					Type or Print Name of Contact Person	
Mary Smith		11/15/04			(123) 456-7890	
Type or Print Name of Authorized Official		Date			Telephone Number	

**Interim Instruction and Invoice Forms (Diagnostic, Treatment, and Therapy
Expenditure Reporting)**

Please see CCS Information Notice No. 03-13

CCS Quarterly Medical Therapy Program (MTP) Claims Preparation Invoice Instructions

The CCS Quarterly MTP Claims Preparation Invoice form is found on Page 8-39. All invoices must be prepared in accordance with these instructions in order to receive reimbursement.

I. Instructions for preparation of the CCS Quarterly MTP Claims Preparation Invoice

CCS County programs are reimbursed for expenditures incurred in the preparation of Medi-Cal and non Medi-Cal claims submitted to the DHS fiscal intermediary for MTP services provided to CCS clients at a MTU/Certified Rehabilitation Unit. Reimbursement is according to the ratio of Medi-Cal caseload to non Medi-Cal caseload.

The Medi-Cal caseload ratio is applied to the expenditures and is reimbursed at 50 percent. The non Medi-Cal ratio is applied to the expenditures and is reimbursed at 100 percent.

A. Caseload Procedures for Reporting Caseload

1. Enter the total number of MTP clients for the quarter in the caseload data box located at the top left portion of the invoice.
2. Enter the number and percentage of Medi-Cal clients of the total MTP clients in the spaces provided.
3. Enter the number and percentage of non Medi-Cal clients in the appropriate spaces.

B. Category/Line Items

1. (I) Total Personnel Expenses

The amounts invoiced for all employees must be supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the actual expenditures for salaries and wages of staff invoiced in Column 1.

Enter in Column 2 the amount claimed at 100 percent State Reimbursement. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3 the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

2. (II) Total Operating Expenses

Enter the actual expenditures for operating expenses in Column 1. **Do not invoice any travel and training costs on this invoice.**

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3, the amount of expenditures claims at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

3. (III) Total Capital Expenses

The definitions of equipment and guidelines for reimbursement of equipment are found on page 8-70.

Enter the total Capital Expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3, the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of column 2 subtracted from Column 1.

4. (IV) Total Indirect Expenses

Enter the total of all indirect expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3 the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of Column 2 subtracted from Column 1.

5. (V) Total Other Expenses

Enter the total other Expenses on this line in Column 1.

Enter in Column 2, the amount of expenditures claimed at 100 percent State Funds. This amount is derived by multiplying the amount in Column 1 by the percentage of non Medi-Cal clients.

Enter in Column 3, the amount of expenditures claimed at 50 percent county and 50 percent state. This is the difference of column 2 subtracted from Column 1.

6. Expenditure Grand Total

Add Totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses, and enter the amount on this line.

C. Source of Funds

1. State General Funds

Enter in Column 2 on the State General Funds line, the amount from Column 2 of the Expenditure Grand Total.

Multiply the Expenditure Grand Total in Column 3 by 50 percent and enter this amount in Column 3 on the State General Funds line.

Add Columns 2 and 3 together and enter the sum in Column 1 on the State General Funds line.

2. County Funds

Subtract the State General Funds amount in Column 3 from the Expenditure Grand Total line in Column 3, and enter this amount on the County Funds line in Column 3 and Column 1.

D. Certification and Signatures

Provide the contact name and telephone number of the county staff who is responsible for processing the expenditure invoice.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice. An original signature is required (signature stamps are not acceptable).

Type or print the name and title of the official who signed the invoice.

COUNTY _____

QUARTER ENDING _____

Month/Day/Year

Medical Therapy Program (MTP) CASELOAD

	Number	%
Straight CCS		
Healthy Families		
Medi-Cal		
TOTAL		

CCS QUARTERLY MEDICAL THERAPY PROGRAM

CLAIMS PREPARATION EXPENDITURE INVOICE

FISCAL YEAR _____

CATEGORY/LINE ITEM	TOTAL EXPENDITURES 1	Non-M/C 100% State 2	M/C 50%State/50%County 3
I. TOTAL PERSONNEL EXPENSE			
II. TOTAL OPERATING EXPENSE			
III. TOTAL CAPITAL EXPENSE			
IV. TOTAL INDIRECT EXPENSE			
V. TOTAL OTHER EXPENSE			
EXPENDITURE GRAND TOTAL			

SOURCE OF FUNDS			
State General Funds			
County Funds			

CERTIFICATION:

I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

AUTHORIZED OFFICIAL

CONTACT PERSON (Type or Print Name)

Signature

Date

AUTHORIZED OFFICIAL

()

TELEPHONE NUMBER

(Type or Print Name)

Revision Date: November 2003

CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL A)

INSTRUCTIONS for COMPLETION

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the Initial Invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following 2 parts:

- Supplemental (Part A) – represents the Initial Invoice that has been approved by the CMS Branch, and any changes that update the information previously reported on the Initial Invoice.

Example: The Initial Invoice showed an expenditure total of \$500 for General Expenses in the 1st Quarter. Several months after the Initial Invoice was submitted to the CMS Branch for reimbursement, the county found a supply order for \$1,000 that was paid in the 1st Quarter.

In order to be reimbursed for the \$1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the 1st Quarter that shows an expenditure total of \$1,500 (\$500 + \$1,000) for General Expenses.

- Supplemental (Part B) – represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

Example: When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the 1st Quarter. To do this, the county must subtract the \$500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of \$1,500 that was reported on the Supplemental (Part A) Invoice. The difference of \$1,000 (\$1,500 - \$500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part A) Invoice for the CCS Program Administrative Expenditure Invoice.

Fiscal Year

- 1) Enter the State fiscal year (FY) for which this invoice applies.

County

- 2) Enter the name of the county for which this invoice applies.

No.

- 3) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on Pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter

- 4) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on Pages 1 and 2 of the Supplemental (Part A) Invoice.

CCS CASELOAD

Column B – Correct Caseload

Medi-Cal Cases

- 5) Enter the Average Total Cases of Open (Active) Medi-Cal Children that was previously reported on the Initial Invoice and any changes to this figure.
- 6) Enter the number of Potential Cases of Medi-Cal Children that was previously reported on the Initial Invoice and any changes to this figure.
- 7) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Cases: Healthy Families (HF)

- 8) Enter the Average Total Cases of Open (Active) HF Children that was previously reported on the Initial Invoice and any changes to this figure.
- 9) Enter the number of Potential Cases of HF Children that was previously reported on the Initial Invoice and any changes to this figure.

- 10) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

Non-Medi-Cal Cases: Straight CCS

- 11) Enter the Average Total Cases of Open (Active) Straight CCS Children that was previously reported on the Initial Invoice and any changes to this figure.
- 12) Enter the number of Potential Cases of Straight CCS Children that was previously reported on the Initial Invoice and any changes to this figure.
- 13) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

Total Non-Medi-Cal Cases

- 14) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

- 15) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

- 16) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 17) Enter the percentage for Potential Cases of Medi-Cal Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 18) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Healthy Families

- 19) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 20) Enter the percentage for Potential Cases of HF Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.

- 21) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Straight CCS

- 22) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 23) Enter the percentage for Potential Cases of Straight CCS Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 24) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

Total Non-Medi-Cal Cases Percentage

- 25) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

- 26) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100%.

ADMINISTRATIVE EXPENDITURES

County

- 27) Enter the name of the county for which this invoice applies.

No.

- 28) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on Pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter

- 29) Enter the dates of the quarter for which the invoice applies.

These dates must be the same on Pages 1 and 2 of the Supplemental (Part A) Invoice.

Column C, Total Expenditures

- 30) Enter the amounts of Total Expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 31) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

Column D, Total Non-Medi-Cal

- 32) Enter the amounts of Total Non-Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how maintenance and transportation (M&T) costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of Total Non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

- a. Subtract all M&T expenditures (which were previously reported on the Initial Invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).
- b. Multiply the remaining balance by the percentage for Total Non-Medi-Cal from the Supplemental (Part) Invoice.
- c. To this end result, add the correct M&T expenditures directly related to non-Medi-Cal clients.
- d. The subsequent total is the correct amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{rcl} + & \text{Total Other Expenses (amounts previously reported and any changes)} & \\ - & \text{All M\&T Expenditures (amounts previously reported and any changes)} & \\ = & \text{Remaining Balance (amounts previously reported and any changes)} & \\ \times & \text{Total Non-Medi-Cal Cases \% (from Supplemental (Part A) Invoice)} & \\ = & \text{Correct Share of Total Other Expenses for Total Non-Medi-Cal Cases} & \\ + & \text{Correct M\&T Expenditures for Non-Medi-Cal Clients} & \\ = & \text{Correct Amount of Total Other Expenses for Total Non-Medi-Cal Cases} & \end{array}$$

- 33) Enter the Total Expenditures for Total Non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

Column E, Straight CCS

- 34) Enter the amounts of Straight CCS expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 35) Enter the Total Expenditures for Straight CCS by adding all entries in Column E.

Column F, Healthy Families (HF)

- 36) Enter the amounts of HF expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 37) Enter the Total Expenditures for HF by adding all entries in Column F.

Column G, Total Medi-Cal

- 38) Enter the amounts of Total Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how maintenance and transportation (M&T) costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of Total Medi-Cal expenditures for Total Other Expenses, use the following formula.

- a. Subtract all M&T expenditures (which were previously reported on the initial invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).
- b. Multiply the remaining balance by the percentage for Total Medi-Cal from the Supplemental (Correct) Invoice.
- c. To this end result, add the correct M&T expenditures directly related to Medi-Cal clients.
- d. The subsequent total is the correct amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{rcl} + & \text{Total Other Expenses (amounts previously reported and any changes)} & \\ - & \text{All M\&T Expenditures (amounts previously reported and any changes)} & \\ = & \text{Remaining Balance (amounts previously reported and any changes)} & \\ \times & \text{Total Medi-Cal Cases \% (from Supplemental (Part A) Invoice)} & \\ = & \text{Correct Share of Total Other Expenses for Total Medi-Cal Cases} & \\ + & \text{Correct M\&T Expenditures for Medi-Cal Clients} & \\ = & \text{Correct Amount of Total Other Expenses for Total Medi-Cal Cases} & \end{array}$$

- 39) Enter the Total Expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

Column H, Medi-Cal Enhanced

- 40) Enter the amounts of Medi-Cal Enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

Only Personnel Expenses and Operating Expenses (i.e., training and travel costs) for SPMP are allowed as expenditures for Medi-Cal Enhanced.

Medi-Cal Enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

Column I, Medi-Cal Non-Enhanced

- 41) Enter the amounts of Medi-Cal Non-Enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; associate staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

Maintenance & Transportation

- 42) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal for maintenance & transportation that were previously reported on the Initial Invoice and any changes to these amounts.

Expenditures for M&T **must be identified directly** to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and Healthy Families.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

SOURCE OF FUNDS

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M, Straight CCS

- 43) Enter the amounts of State and County funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Straight CCS expenditures is 50% State funds and 50% County funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column E by 50%.

The amount of County funds is determined by multiplying the Total Expenditures in Column E by 50%.

Column N, Healthy Families

- 44) Enter the amounts of Federal, State, and County funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Healthy Families expenditures is 65% Federal funds (Title XXI), 17.5% State funds, and 17.5% County funds.

The amount of Federal funds is determined by multiplying the Total Expenditures in Column F by 65%.

The amount of State funds is determined by multiplying the Total Expenditures in Column F by 17.5%.

The amount of County funds is determined by multiplying the Total Expenditures in Column F by 17.5%.

Column L, Total Non-Medi-Cal

- 45) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.
- 46) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

Column P, Medi-Cal Enhanced

- 47) Enter the amounts of State and Federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal Enhanced expenditures is 25% State funds and 75% Federal (Title XIX) funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column H by 25%.

The amount of Federal funds is determined by multiplying the Total Expenditures in Column H by 75%.

Column Q, Medi-Cal Non-Enhanced

- 48) Enter the amounts of State and Federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal Non-Enhanced expenditures is 50% State funds and 50% Federal (Title XIX) funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column I by 50%.

The amount of Federal funds is determined by multiplying the Total Expenditures in Column I by 50%.

Column O, Total Medi-Cal

- 49) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

- 50) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

Column K, Total Expenditures

- 51) Enter the amounts for Medi-Cal State and Federal (Title XIX) funds from Column O to Column K.
- 52) Enter the amounts for Healthy Families State, County, and Federal (Title XXI) funds from Column N to Column K.
- 53) Enter the amounts for Straight CCS State and County funds from Column M to Column K.

Total Source of Funds

- 54) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

CERTIFICATION

- 55) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B).
- 56) Type or print the name of the authorized official.
- 57) Enter the date that the signature was affixed.
- 58) Type or print the name of the contact person for the expenditure invoice.
- 59) Enter the telephone number for the contact person.

SUBMISSION

- 60) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature.
- No additional copies are required.
- 61) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Services
Children's Medical Services Branch
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413
Attention: Program Support Section

Supplemental Invoices (Parts A and B) shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2004-2005 ends June 30, 2005. Supplemental Invoices (Parts A and B) for FY 2004-2005 are due December 31, 2005.

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM

FISCAL YEAR _____

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

COUNTY _____

NO.: _____

QUARTER _____

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

COUNTY: _____

NO.: _____

QUARTER: _____

A	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS	HEALTHY FAMILIES	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
				50/50 State/County	65/17.5/17.5 Fed/State/Co			
B	C=D+G	D=E+F	E	F	G=H+I	H	I	
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	TOTAL EXPENDITURES							
	Maintenance & Transportation	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
	SOURCE OF FUNDS							
J	K=L+O	L	M	N	O=P+Q	P	Q	
	MEDI-CAL							
	State Funds							
	Federal Funds (Title XIX)							
	HEALTHY FAMILIES							
	State Funds							
	County Funds							
	Federal Funds (Title XXI)							
	STRAIGHT CCS							
	State Funds							
	County Funds							
	TOTAL SOURCE OF FUNDS							

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official		Type or Print Name of Contact Person	
		()	
Type or Print Name of Authorized Official	Date	Telephone Number	

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM

FISCAL YEAR 2004-2005

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

COUNTY ANYWHERENO.: 1QUARTER July 1, 2004 - September 30, 2004

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
A	B	C
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children	1,736	62.65%
Potential Cases of Medi-Cal Children	218	7.87%
TOTAL MEDI-CAL CASES	1,954	70.52%
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	95	3.43%
Potential Cases of HF Children	37	1.34%
TOTAL HEALTHY FAMILIES CASES	132	4.76%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	536	19.34%
Potential Cases of Straight CCS Children	149	5.38%
TOTAL STRAIGHT CCS CASES	685	24.72%
TOTAL NON-MEDI-CAL CASES	817	29.48%
TOTAL CASELOAD	2,771	100.00%

State of California - Health and Human Resources Agency			Department of Health Services - Children's Medical Services Branch					
CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)								
COUNTY: <u>ANYWHERE</u>			NO.: <u>1</u>		QUARTER: <u>July 1, 2004 - September 30, 2004</u>			
			NON-MED-CAL			MEDI-CAL		
	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	TOTAL NON-MEDI-CAL	STRAIGHT CCS 50/50 State/County	HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
A	B	C=D+G	D=E+F	E	F	G=H+I	H	I
I.	Total Personnel Expenses	197,512	58,227	48,825	9,402	139,285	98,436	40,849
II.	Total Operating Expenses	49,207	14,506	12,164	2,342	34,701	26,507	8,194
III.	Total Capital Expenses	0	0	0	0	0		0
IV.	Total Indirect Expenses	23,611	6,961	5,837	1,124	16,650		16,650
V.	Total Other Expenses	8,053	1,000	1,000	0	7,053		7,053
	TOTAL EXPENDITURES	278,383	80,693	67,826	12,868	197,690	124,943	72,747
	Maintenance & Transportation	\$ 4,500	\$ 750	\$ 250	\$ 500	\$ 3,750		
	SOURCE OF FUNDS							
	J	K=L+O	L	M	N	O=P+Q	P	Q
	MEDI-CAL							
	State Funds	67,609				67,609	31,236	36,373
	Federal Funds (Title XIX)	130,081				130,081	93,707	36,373
	HEALTHY FAMILIES							
	State Funds	2,252	2,252		2,252			
	County Funds	2,252	2,252		2,252			
	Federal Funds (Title XXI)	8,364	8,364		8,364			
	STRAIGHT CCS							
	State Funds	33,913	33,913	33,913				
	County Funds	33,913	33,913	33,913				
	TOTAL SOURCE OF FUNDS	278,383	80,693	67,826	12,868	197,690	124,943	72,747
CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed								
Signature of Authorized Official			Date			Jane Doe Type or Print Name of Contact Person (123) 456-7890 Telephone Number		
Mary Smith			12/01/04					

CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL B)

INSTRUCTIONS for COMPLETION

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the Initial Invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following 2 parts:

- Supplemental (Part A) – represents the Initial Invoice that has been approved by the CMS Branch, and any changes that update the information previously reported on the Initial Invoice.

Example: The Initial Invoice showed an expenditure total of \$500 for General Expenses in the 1st Quarter. Several months after the Initial Invoice was submitted to the CMS Branch for reimbursement, the county found a supply order for \$1,000 that was paid in the 1st Quarter.

In order to be reimbursed for the \$1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the 1st Quarter that shows an expenditure total of \$1,500 (\$500 + \$1,000) for General Expenses.

- Supplemental (Part B) – represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

Example: When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the 1st Quarter. To do this, the county must subtract the \$500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of \$1,500 that was reported on the Supplemental (Part A) Invoice. The difference of \$1,000 (\$1,500 - \$500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part B) Invoice for the CCS Program Administrative Expenditure Invoice.

Fiscal Year

- 1) Enter the State fiscal year (FY) for which this invoice applies.

County

- 2) Enter the name of the county for which this invoice applies.

No.

- 3) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter

- 4) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

CCS CASELOAD

Column B – Difference in Caseload

Medi-Cal Cases

- 5) Enter the difference for Average Total Cases of Open (Active) Medi-Cal Children by subtracting the Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.
- 6) Enter the difference for Potential Cases of Medi-Cal Children by subtracting the number of Potential Cases of Medi-Cal Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of Medi-Cal Children on the Supplemental (Part A) Invoice.
- 7) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Cases: HF

- 8) Enter the difference for Average Total Cases of Open (Active) Healthy Families (HF) Children by subtracting the Average Total Cases of Open (Active) HF Children that were

previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Healthy Families (HF) Children on the Supplemental (Part A) Invoice.

- 9) Enter the difference for Potential Cases of HF Children by subtracting the number of Potential Cases of HF Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 10) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

Non-Medi-Cal Cases: Straight CCS

- 11) Enter the difference by subtracting the Average Total Cases of Open (Active) Straight CCS Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Straight CCS Children on the Supplemental (Part A) Invoice.
- 12) Enter the difference by subtracting the number of Potential Cases of Straight CCS Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of Straight CCS Children on the Supplemental (Part A) Invoice.
- 13) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

Total Non-Medi-Cal Cases

- 14) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

- 15) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column E – Percent of Grant Total

Medi-Cal Cases Percentages

- 16) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.
- 17) Enter the difference by subtracting the percentage for Potential Cases of Medi-Cal Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of Medi-Cal Children on the Supplemental (Part A) Invoice.
- 18) Enter the percentage for Total Medi-Cal Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Percentages: HF

- 19) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.
- 20) Enter the difference by subtracting the percentage for Potential Cases of HF Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 21) Enter the percentage for Total HF Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Percentages: Straight CCS

- 22) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.
- 23) Enter the difference by subtracting the percentage for Potential Cases of HF Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 24) Enter the percentage for Total Straight CCS Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Total Non-Medi-Cal Cases Percentage

- 25) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

- 26) Enter the percentage for Total Caseload by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

The Total Caseload Percentage must equal zero percent (0%).

ADMINISTRATIVE EXPENDITURES

County

- 27) Enter the name of the county for which this invoice applies.

No.

- 28) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter

- 29) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

Column C, Total Expenditures

- 30) Enter the difference for each category/line item listed in Column B by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.
- 31) Enter the difference for Total Expenditures by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

Column D, Total Non-Medi-Cal

- 32) Enter the difference for each category/line item listed in Column B by subtracting the Total Non-Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.
- 33) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Non-Medi-Cal that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

Column E, Straight CCS

- 34) Enter the difference for each category/line item listed in Column B by subtracting the Straight CCS expenditures that were previously reported on the Initial Invoice from the correct Straight CCS expenditures reported on the Supplemental (Part A) Invoice.
- 35) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Straight CCS that were previously reported on the Initial Invoice from the correct Total Expenditures for Straight CCS reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column E.

Column F, Healthy Families (HF)

- 36) Enter the difference for each category/line item listed in Column B by subtracting the HF expenditures that were previously reported on the Initial Invoice from the correct HF expenditures reported on the Supplemental (Part A) Invoice.
- 37) Enter the difference for Total Expenditures by subtracting the Total Expenditures for HF that were previously reported on the Initial Invoice from the correct Total Expenditures for HF reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column F.

Column G, Total Medi-Cal

- 38) Enter the difference for each category/line item listed in Column B by subtracting between the Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.
- 39) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

Column H, Medi-Cal Enhanced

- 40) Enter the difference for Total Personnel Expenses and Total Operating Expenses listed in Column B by subtracting the Medi-Cal Enhanced expenditures that were previously reported on the Initial Invoice from the correct Medi-Cal Enhanced expenditures reported on the Supplemental (Part A) Invoice.

- 41) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column H.

Column I, Medi-Cal Non-Enhanced

- 42) Enter the difference for each category/line item listed in Column B by subtracting the Medi-Cal Non-Enhanced expenditures that were previously reported on the Initial Invoice from the correct Medi-Cal Non-Enhanced expenditures reported on the Supplemental (Part A) Invoice.
- 43) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Non-Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Non-Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column I.

Maintenance & Transportation (M&T)

- 44) Enter the differences for Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal by subtracting the Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal amounts that were previously reported on the Initial Invoice from the correct Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal amounts reported on the Supplemental (Part A) Invoice.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and Healthy Families.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

SOURCE OF FUNDS

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M, Straight CCS

- 45) Enter the difference for each source of funds listed in Column J by subtracting the State and County funds that were previously reported on the Initial Invoice from the correct State and County funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Straight CCS expenditures is 50% State funds and 50% County funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column E by 50%.

The amount of County funds is determined by multiplying the Total Expenditures in Column E by 50%.

- 46) Enter the Total Source of Funds by adding all entries in Column M.

Column N, HF

- 47) Enter the difference for each source of funds listed in Column J by subtracting the Federal, State, and County funds that were previously reported on the Initial Invoice from the correct Federal, State, and County funds reported on the Supplemental (Part A) Invoice.

The funding distribution for HF expenditures is 65% Federal (Title XXI) funds, 17.5% State funds, and 17.5% County funds.

The amount of Federal (Title XXI) funds is determined by multiplying the Total Expenditures in Column F by 65%.

The amount of State funds is determined by multiplying the Total Expenditures in Column F by 17.5%.

The amount of County funds is determined by multiplying the Total Expenditures in Column F by 17.5%.

- 48) Enter the Total Source of Funds by adding all entries in Column N.

Column L, Total Non-Medi-Cal

- 49) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 50) Enter Total Source of Fund by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

Column P, Medi-Cal Enhanced

- 51) Enter the difference for each source of funds listed in Column J by subtracting the State and Federal funds that were previously reported on the Initial Invoice from the correct State and Federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal Enhanced expenditures is 25% State funds and 75% Federal (Title XIX) funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column H by 25%.

The amount of Federal (Title XIX) funds is determined by multiplying the Total Expenditures in Column H by 75%.

- 52) Enter the Total Source of Funds by adding all entries in Column P.

Column Q, Medi-Cal Non-Enhanced

- 53) Enter the difference for each source of funds listed in Column J by subtracting the State and Federal funds that were previously reported on the Initial Invoice from the correct State and Federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal Non-Enhanced expenditures is 50% State funds and 50% Federal (Title XIX) funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column I by 50%.

The amount of Federal (Title XIX) funds is determined by multiplying the Total Expenditures in Column I by 50%.

- 54) Enter the Total Source of Funds by adding all entries in Column Q.

Column O, Total Medi-Cal

- 55) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

- 56) Enter Total Source of Fund by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

Column K, Total Expenditures

- 57) Enter the amounts for Medi-Cal State and Federal funds (Title XIX) from Column O to Column K.

- 58) Enter the amounts for Healthy Families State, County, and Federal funds (Title XXI) from Column N to Column K.
- 59) Enter the amounts for Straight CCS State and County funds from Column M to Column K.

Total Source of Funds

- 60) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the sum of Columns M and N.

The entry in Column O must equal the sum of Columns P and Q.

The entry in Column K must equal the sum of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

CERTIFICATION

- 61) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B).
- 62) Type or print the name of the authorized official.
- 63) Enter the date that the signature was affixed.
- 64) Type or print the name of the contact person for the expenditure invoice.
- 65) Enter the telephone number for the contact person.

SUBMISSION

- 66) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature.

No additional copies are required.

- 67) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Services
Children's Medical Services Branch
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413
Attention: Program Support Section

Supplemental Invoices (Parts A and B) shall be submitted **no later than December 31st** after the end of each fiscal year.

Example: FY 2004-2005 ends June 30, 2005. Supplemental Invoices (Parts A and B) for FY 2004-2005 are due December 31, 2005.

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM

FISCAL YEAR _____

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

COUNTY _____

NO.: _____

QUARTER _____

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
A	B	C
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

COUNTY: _____

NO.: _____

QUARTER: _____

A	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT	HEALTHY	TOTAL	ENHANCED	NON-ENHANCED
				CCS	FAMILIES			
			50/50	65/17.5/17.5		25/75	50/50	
			State/County	Fed/State/Co		State/Federal	State/Federal	
B		C=D+G	D=E+F	E	F	G=H+I	H	I
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	TOTAL EXPENDITURES							
	Maintenance & Transportation	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____		
	SOURCE OF FUNDS							
J		K=L+O	L	M	N	O=P+Q	P	Q
MEDI-CAL								
	State Funds							
	Federal Funds (Title XIX)							
HEALTHY FAMILIES								
	State Funds							
	County Funds							
	Federal Funds (Title XXI)							
STRAIGHT CCS								
	State Funds							
	County Funds							
TOTAL SOURCE OF FUNDS								

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official

Type or Print Name of Contact Person

()

Type or Print Name of Authorized Official

Date

Telephone Number

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM

FISCAL YEAR 2004-2005

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

COUNTY ANYWHERE NO.: 1QUARTER July 1, 2004 - September 30, 2004

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
A	B	C
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children	0	
Potential Cases of Medi-Cal Children	0	
TOTAL MEDI-CAL CASES	0	
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	95	3.43%
Potential Cases of HF Children	37	1.33%
TOTAL HEALTHY FAMILIES CASES	132	4.76%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	-95	-3.43%
Potential Cases of Straight CCS Children	-37	-1.33%
TOTAL STRAIGHT CCS CASES	-132	-4.76%
TOTAL NON-MEDI-CAL CASES	0	0.00%
TOTAL CASELOAD	0	0.00%

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)COUNTY: ANYWHERE NO.: 1 QUARTER: July 1, 2004 - September 30, 2004

	CATEGORY/LINE ITEM	TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT	HEALTHY	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
				CCS	FAMILIES			
				50/50	65/17.5/17.5			
			State/County	Fed/State/Co				
A	B	C=D+G	D=E+F	E	F	G=H+I	H	I
I.	Total Personnel Expenses	0	0	-9,402	9,402	0	0	0
II.	Total Operating Expenses	0	0	-2,342	2,342	0	0	0
III.	Total Capital Expenses	0	0	0	0	0		0
IV.	Total Indirect Expenses	0	0	-1,124	1,124	0		0
V.	Total Other Expenses	0	0	0	0	0		0
	TOTAL EXPENDITURES	0	0	-12,868	12,868	0	0	0
	Maintenance & Transportation	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0		
	SOURCE OF FUNDS							
	J	K=L+O	L	M	N	O=P+Q	P	Q
MEDI-CAL								
	State Funds	0				0	0	0
	Federal Funds (Title XIX)	0				0	0	0
HEALTHY FAMILIES								
	State Funds	2,252	2,252		2,252			
	County Funds	2,252	2,252		2,252			
	Federal Funds (Title XX)	8,364	8,364		8,364			
STRAIGHT CCS								
	State Funds	-6,434	-6,434	-6,434				
	County Funds	-6,434	-6,434	-6,434				
TOTAL SOURCE OF FUNDS		0	0	-12,868	12,868	0	0	0

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official		Jane Doe	
Type or Print Name of Authorized Official		Type or Print Name of Contact Person	
Mary Smith		(123) 456-7890	
Type or Print Name of Authorized Official		Telephone Number	
Date			
12/01/04			

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Management of Equipment Purchased with State Funds

I. County/City Guidelines for Equipment

All equipment purchased with funds furnished in whole or in part by the State under the terms of this agreement shall be the property of the State and shall be subject to the following provisions.

- A. The county/city shall use its own procurement process when purchasing equipment. The cost of equipment includes the purchase price plus all costs to acquire, install, and prepare equipment for its intended use. Examples of items may include computers, printers, photocopiers, etc.
- B. All equipment purchased under this agreement shall be used only to conduct business related to programs funded by Children's Medical Services (CMS) Branch.
- C. The county/city shall maintain and administer, in accordance with sound business practice, a program for the utilization, maintenance, repair, protection, and preservation of state property to assure its full availability and usefulness.
- D. The county/city shall forward to the CMS Branch regional office with each quarterly invoice a listing of all new equipment purchased during the quarter on the form entitled Equipment Purchased with State Funds, CMSB A-1 (see page 8-72). The CMS Branch will forward identification tags to the attention of the contact person identified on the form. All equipment must have State identification tags affixed to the front left-hand corner of them.
- E. Invoices for budgeted equipment purchases are to be submitted only after the equipment is received.
- F. The county/city shall submit an annual inventory of state purchased equipment on the form entitled Annual Inventory of State Furnished Equipment, CMSB A-2 (see page 8-74).
- G. Final disposition of all equipment shall be in accordance with instructions from the State and reported on the Property Survey Report (see Page 8-76).
- H. Management of all county/city equipment purchased with State funds shall be coordinated through the CMS Administrative Consultant in accordance with the procedures described in Section II below.

II. Tagging and Disposal of State Purchased Equipment

- A. Equipment subject to these procedures is defined in the State Administrative Manual (SAM), Section 8602, as all equipment with a unit cost of \$5,000 or more and a life expectancy of more than four years that is used to conduct state business.

- B. In response to the CMSB A-1 received from the county/city, the CMS Branch Administrative Consultant forwards state tag(s) to the county/City with an equipment identification tag transmittal letter (see Page 8-78).
- C. State-purchased equipment used by counties/cities in performance of CMS program obligations must be disposed of according to DHS procedures. Disposition occurs when funding is terminated; the useful life of the equipment is expended; the equipment is determined by the State to be obsolete for purpose for which it was intended; or any other reason deemed by the State to be in its own best interest.
 - 1. The county/city representative submits a written request to the CMS Branch Regional Administrative Consultant to dispose of equipment, or the CMS Branch Administrative Consultant notifies the county/city in writing that certain equipment is scheduled for disposition.
 - 2. The CMS Branch Regional Administrative Consultant notifies the DHS Business Services Section, Property Unit, of the need for equipment disposition by submitting a completed Form 152, "Property Survey Report (see page 8-76).

CMSB A-1
EQUIPMENT PURCHASED WITH STATE FUNDS

County /City Name: _____

Fiscal Year Budgeted: _____

Complete Address: _____

DHS Requester: _____

Program Name: _____

DHS Contact Person: _____

Program Contact Telephone No.: _____

HDS Contact Telephone No: _____

DHS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, List VIN No.)
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			

Revised: July 2001
CMSB A-1 (7/01)

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CMSB A-2
ANNUAL INVENTORY OF STATE FURNISHED EQUIPMENT

County /City Name: _____

Date of Report: _____

Complete Address: _____

CMS Administrative Consultant _____

Program Name: _____

Consultants Address: _____

Program Contact Telephone No.: _____

Consultant's Telephone No: _____

DHS PROPERTY CONTROL USE ONLY STATE ID TAG NO.	Quantity	Description 1. Include Manufacturer's name, model no./type, size, and/or capacity. 2. If motor vehicle, list year, make model no., type of vehicle (van, sedan, truck, etc.) 3. If Van, include passenger capacity.	Base Cost Per Unit	DHS Order or Document No.	Date Received	Serial No. (If Motor Vehicle, List VIN No.)
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			

Revised: July 2001
CMSB A-2 (7/01)

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PROPERTY SURVEY REPORT

STD. 152 (REV. 9/00)

**Record as of disposition date (lost, stolen
or destroyed property--record as of the
date such determination was made).**

RETURN TO:

REPORTING DEPARTMENT/AGENCY

Department of Health Services

Attention

Asset Management. Unit

☐ Walter Borgelt
☐ Teresa Madeira

DOCUMENT NUMBER

RETURN ADDRESS

P.O. Box 997413 1501 Capitol Avenue, Suite 71.2101 MS 1404

IMS CODE

A-22

DATE

CITY

Sacramento, California

ZIP CODE

95899-7413

REPLACEMENTS:
SEE PURCHASE ESTIMATE
NUMBER

Authority is requested to dispose of the
following State property:

FUND OWNED BY


CONTACT PERSON

TELEPHONE NUMBER

()

ATTACHED

ITEM-DESCRIPTION, MODEL NUMBER, SERIAL NUMBER, ETC.	STATE IDENT. NO. (1)	DATE PURCHASED	ORIGINAL COST	LOCATION (CITY)	PRESENT CONDITION	DISP. CODE*	PRICE OFFERED (2)	PRICE RECEIVED (3)	RECEIPT NUMBER
1.		/ /							
2.		/ /							
3.		/ /							
4.		/ /							
5.		/ /							
6.		/ /							
7.		/ /							

(1) PROPERTY TAG NUMBER OR  NUMBER FOR VEHICLE



(2) DO NOT OBTAIN BIDS ON TRADE-INS. ESTIMATE PRICE OFFERED

(3) AMOUNT ALLOWED IF TRADED IN OR SOLD

***DISPOSITION CODE**

1. TRADE-IN
 2. SALE (INCLUDING JUNK SALE)
 3. JUNK — VALUELESS GS
 4. LOST** } department of general
 5. STOLEN** } services
 6. DESTROYED (AS BY FIRE, ETC.) } REVIEW FOR 4, 5, & 6 IS NOT
 7. TO BE SALVAGED } REQUIRED
 8. PROPERTY REUTILIZATION—GENERAL SERVICES, SURPLUS PROPERTY
- **IF LOST, STOLEN OR DESTROYED, REFER TO SAM SECTION 8643 FOR INSTRUCTIONS.

EXPLANATION-REASONS FOR PROPOSED DISPOSITION OF EACH ITEM

APPROVED BY PROPERTY SURVEY BOARD		CERTIFICATION OF DISPOSITION	REVIEWED BY DEPT. OF GENERAL SERVICES
(A minimum of two signatures is required)		<p>The above described property was disposed of as follows: (specify if no consideration was received)</p>	<p>FOR DGS REVIEW, SEND TO:</p> <p>Department of General Services State Agency for Surplus Property NORTH SOUTH 1700 National Drive 701 Burning Tree Road Sacramento, CA Fullerton, CA 92633 95834</p> <p>FOR DISPOSITION OF VEHICLES AND MOBILE EQUIPMENT, SEND TO:</p> <p>Department of General Services Office of Fleet Administration 802 Q Street Sacramento, CA 95814</p>
<p>The above statements regarding state property are true and correct; culpable negligence (check appropriate box)</p> <p><input checked="" type="checkbox"/> was <input type="checkbox"/> was not involved in loss, theft, or damage; the disposition proposed is better for the public interest.</p>			
SIGNATURE	DATE SIGNED	DISPOSAL DATE	
1.		/ /	
		SIGNATURE (Officer Supervising Disposal of the Property)	SIGNATURE
2.			
		TITLE	DATE SIGNED
3.			

(DO NOT USE HALF SHEETS OR STAPLES)

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Equipment Identification Tag Transmittal Letter

Date

County/City Program
Address
City, State Zip Code

Dear _____:

EQUIPMENT IDENTIFICATION TAG TRANSMITTAL

In accordance with State requirements for equipment management, this equipment identification tag transmittal is being issued in response to your request dated _____ and detailed on the "Equipment Purchased with State Funds" form (CMSB A-1). The enclosed Department of Health Services equipment identification tag(s) is/are to be affixed by county/city staff to the equipment as follows:

ITEM DESCRIPTION	STATE ID NUMBER
------------------	-----------------

All tags must be placed on the front left-hand corner of the item. Manufacturer's marks must be left intact.

If you have any questions regarding the instructions in this letter or the appropriate procedures for affixing the enclosed tag(s), please contact me at () ____ - ____.

Sincerely,

--State CMS Branch Staff Name--
Administrative Consultant
Children's Medical Services Branch

Enclosure(s)

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